PRINTED: 09/27/2018 FORM APPROVED

| | E & MEDICAID SERVICES | | THE PARTY OF THE P | OMB NO. 0938-03 |
|--|--|---------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
| 5-14 T | 09G223 | B. WING _ | | 08/30/2018 |
| NAME OF PROVIDER OR SUPPLIER | In the second se | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/00/2010 |
| COMMUNITY MULTI SERVICE | ES, INC | | WASHINGTON, DC 20012 | |
| PREFIX (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETIO |
| W 000 INITIAL COMMENT | rs | W 000 |) | = |
| 08/28/18 through 08 selected from a pop three males with va disabilities. This sur | rvey was conducted from 8/30/18. Two clients were culation of one female and rious degrees of intellectual vey was conducted utilizing mental survey process. | | | |
| observations, intervi administrative recor Note: The below are | e abbreviations that may | | | 1 |
| DON - Direct of Nurs LPN - Licensed Prac MG - Milligram PCP - Primary Care | ctical Nurse | | | |
| POS - Physician's O PO - Physician Orde QIDP - Qualified Inte Professional RN - Registered Nur. | rder Sheets er ellectual Disabilities se | | | ř |
| BSP - Behavior Supp IPP - Individualized F TID - Three times a d BID - Two times a da | Program Plan day Dy | | | |
| MAR - Medication Ad N 239 INDIVIDUAL PROGE CFR(s): 483.440(c)(5 | RAM PLAN | W 239 | | |
| appropriate expression replacement of inappropriate and inappropriate appropriate appropri | ives in the individual pecify provision for the on of behavior and the ropriate behavior, if | | | ¥ :: |
| | vior that is adaptive or | MATE IDE | TITLE | (X6) DATE, |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: D9HG11

Facility ID: 09G223

If continuation sheet Page 1 of 8

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/27/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 09G223 B: WING NAME OF PROVIDER OR SUPPLIER 08/30/2018 STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 239 Continued From page 1 W 239 appropriate. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a training program that provided specific interventions to manage a client's use of a toothbrush in an unsanitary manner for one (1) of the two (2) clients in the sample (Client #1). Findings included: On 08/28/18 at 8:57 AM, Client #1 was observe holding his toothbrush as he sat at the dining room table. At approximately 9:00 AM, Client #1 placed his toothbrush in his pocket. At 10:48 AM, Psychologist will update BSP to address Client #1 was observed at his day program. Client the target behavior and intervention to #1 was sitting at the table holding his toothbrush. manage client's use of a toothbrush in At 10:58 AM, the day program staff stated that a sanitary manner. The staff will receive Client #1 likes to hold his toothbrush and will go training from the psychologist. into the bathroom to brush his teeth. When asked, the day program staff stated that the client does not have a toothbrush holder. At 3:23 PM, Client #1 arrived home from his day program. At 3:44 PM Client #1 was observe riding his stationary bike as he held his toothbrush. On 08/29/18 beginning at 9:29 AM, review of Client #1's IPP and BSP revealed the plan failed to address Client #1's behavior of walking around with his toothbrush in his hand. Interview with the QIDP on 08/29/18 at 2:00 PM,

not addressed.

revealed Client #1 behavior of walking around with his toothbrush in a unsanitary manner was

At the time of survey, the facility failed to

PRINTED: 09/27/2018 1

| CENTE | | E & MEDICAID SERVICES | | | 04 | FORM APPROVE |
|--------------------------|--|---|--|--|---|--|
| STATEMEN | NT OF DEFICIENCIES I OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | DER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION | | | MB NO. 0938-039 (X3) DATE SURVEY COMPLETED |
| | | 09G223 | B. WING | | | 08/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CIT | Y, STATE, ZIP CODE | UUI VUI AU I U |
| COMMU | JNITY MULTI SERVICE | | | WASHINGTON, DC | 20012 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER' (EACH CORRI | 'S PLAN OF CORRECTION ECTIVE ACTION SHOULD E ENCED TO THE APPROPRI DEFICIENCY) | BE COMPLETION |
| W 239 | Continued From pag | | W 23 | 39 | | 2 |
| | incorporate interven | ntions to address Client #1's | | | | 27 |
| W 322 | behavior. PHYSICIAN SERVI CFR(s): 483.460(a)(| | W 32 | 22 | | |
| | 400 | ovide or obtain preventive and | | | | į |
| | Based on observation review, the facility fail nursing staff obtained | not met as evidenced by: on, interview and record illed to ensure that the id timely fungal nail culture | | | | |
| | results for one (1) of (Client #1). | two (2) clients in the sample | | | | 4 |
| į | Findings included: | | | | | |
| 8 | During the morning n at 7:27 AM, Client #1 shoe. Observation of revealed all ten toe na | medication pass on 08/29/18, I was wearing an open toe f the client's toe nails ails were long. | | the podiatrist's of future, the nursing | ult was collected for fice by the RN. I ng staff will review and follow with the | In the w all |
| r n | podiatry consult dated nail culture was perfo "report to follow." How | e the results of the culture | | recommendation All medical servi and signed by the responsible to co | ns. ice sheets will be ne nurse. The nur ollect all results. f wil receive addit cal reports and | reviewed se is |
| a h | approximately 2:00 PN | rith the DON on 08/30/18, at M, the DON stated that she ferent location and she diatrist for clarity. | | The second secon | 10. | 10/19/10 |

At the time of the survey, the nursing staff failed to obtain a culture report from the podiatrist

PRINTED: 09/27/2018 /ED 391

| CENT | ERS FOR MEDICAR | E & MEDICAID SERVICES | | | FORM AP | PROVE |
|--------------------------|---|--|----------------------------|---|---|---------------------------|
| STATEME | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A. BUILDING | PLE CONSTRUCTION G | OMB NO. 09 (X3) DATE SL COMPLE | JRVEY |
| | | 09G223 | B WING_ | | 00/00/ | |
| NAME OF | PROVIDER OR SUPPLIER | | ' | STREET ADDRESS, CITY, STATE, ZIP C | 08/30/2 | 2018 |
| | JNITY MULTI SERVIC | | | WASHINGTON, DC 20012 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE CO | (X5) IMPLETION DATE |
| W 322 | Continued From pa | age 3 | W 322 | | 7 | |
| W 331 | timely. NURSING SERVIC CFR(s): 483.460(c) | EES | W 331 | | | |
| | The facility must pro | ovide clients with nursing nce with their needs. | | The nursing staff will be r reviewing all medical repo- follow up with the recommendation. The DON will review medical | orts and nendations on ti lical records | |
| | Based on observat review, the facility's ensure that each CI was ordered, (II) fail Brimonidine was ava | s not met as evidenced by: ion, interview, and record nursing staff (I) failed to ient's medication for Prozac ed to ensure an order for ailable during medication to (2) of four (4) clients y (Client #1 and 4). | | on a quarterly basis for co | ompliance. 10/ | '18/18 |
| | Findings included: | | | | 9 | |
| | was observed utterin inappropriate langua to himself. Client#1 | nning at 8:47 AM, Client #1 g profanity, using ge and was observed talking was observed at his day t 10:48 AM talking to himself. | | | | |
| í | At 10:53 AM, the day Client #1 to participa | program staff encouraged te in a game of bingo with his e refused and continued to | | | ě | |

order for Prozac.

and continue Seroquel."

On 08/29/18, at 10:03 AM, review of Client #1's Psychiatry Assessment dated 06/01/18, revealed a recommendation to "add Prozac 40 mg daily

On 08/29/18, beginning at 10:15 AM., review of Client #1's MAR and POS book failed to reveal an

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/27/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 09G223 B. WING NAME OF PROVIDER OR SUPPLIER 08/30/2018 STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) W 331 Continued From page 4 W 331 On 08/29/18, at 11:55 AM, interview with the QIDP revealed Client #1 did not start his Prozac because it was not presented to the human rights committee. On 08/30/18, at 9:44 AM, interview with the DON revealed Client #1's Prozac should have been ordered within a couple of days after the psychiatrist prescribed the Prozac. At the time of the survey, the facility's nursing services failed to ensure Client #1's medication for Prozac was ordered as recommended by the psychiatrist. (Cross Reference W388) On 08/28/18. The nursing staff obtained the copy of beginning at 5:27 PM, the LPN was observed the physician order sheet from the administering Brimonidine eye drops into Client pharmacy. 10/3/18 #4's eyes. On 08/28/18, beginning at 6:15 PM, review of Client #4's MAR and POS book failed to reveal an order for Brimonidine eye drops. The nursing staff will be retrained on On 08/28/18, at 6:20 PM, the LPN reviewed the reviewing physician order sheet, pharmacy MAR and the POS book for the aforementioned label and MAR for consistency. DON order. At 6:24 PM, the LPN stated that she was will monitor for compliance. 10/18/18 not able find the order for the Brimonidine eye drop. On 08/29/18, at 9:44 AM, the QIDP presented an order for the aforementioned medication dated

accordance with the PO.

03/02/17. It was then reviewed by the surveyor to ensure that the medication administered was in

At the time of the survey, the facility's nursing services failed to ensure Client #4's order for

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/27/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 09G223 B. WING. 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 331 Continued From page 5 W 331 review prior to medication administration. W 368 DRUG ADMINISTRATION W 368 The nursing staff will be retrained on CFR(s): 483.460(k)(1) reviewing physician order sheet to adhere to the time restriction. The The system for drug administration must assure DON will monitor the MAR for that all drugs are administered in compliance with compliance quarterly. the physician's orders. 10/18/18 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each client's prescribed drugs were administered in accordance with physician's orders, for one (1)of four (4) clients receiving medications (Client #3). Findings included: On 08/28/18, beginning at 5:13 PM, during the evening medication administration, the LPN was observed preparing Client #3's medications. At 5:18 PM, Client #3 administered his Tamsulosin after the LPN handed the medication to him. During this time, review of the label on the medication container showed instructions to give the medication 30 minutes after eating. However, Client #3 was observed eating his dinner at 6:03 PM, after his medication was administered. On 08/28/18, at 6:15 PM review of the POS,

each day."

dated 08/01/18, showed an order for Tamsulosin 0.4 mg. The order stated to take "1 capsule by mouth every day 30 minutes after the same meal

Interview with the DON on 08/29/18, at 9:50 AM, confirmed that Client #3 should have received the

| CENTERS FOR MEDI | ALTH AND HUMAN SERVICES CARE & MEDICAID SERVICES | PRINTED: 09/27/20 FORM APPROV OMB NO. 0938-03 |
|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED |
| | 09G223 | B. WING |
| NAME OF PROVIDER OR SUP | PLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| COMMUNITY MULTI SER | | WASHINGTON, DC 20012 |
| PREFIX (EACH DEF) | RY STATEMENT OF DEFICIENCIES DENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIO TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) |
| W 368 Continued Fro | m page 6 | W 368 |
| | d medication 30 minutes after his | VV 300 |
| capsule 30 min prescribed. | ne survey, the facility failed to 3 received Tamsulosin 0.4 mg utes after his dinner as | |
| W 388 DRUG LABELING CFR(s): 483.460(m)(1)(i) | | W 388 The order for the identified eye drops was collected from the pharmacy and |
| Labeling for dru on currently acc practices, | gs and biologicals must be based epted professional principles and | placed in the MAR book. Primary nurse |
| review, the facili pharmacist labe accordance with | D is not met as evidenced by: rvation, interview and record ty failed to ensure that the led each bottle of Brimonidine in each physician order, for one (1) s receiving medications (Client | the importance of obtaining physician order sheet for each medication |
| Findings include | ď; | administered. Primary Care nurse will monitor for compliance monthly. 10/19/18 |
| During the verifice that the label on | 5:27 PM, the LPN instilled one ine into Client #4's left eye. ation process, it was discovered the bottle of the Brimonidine eye ill one drop in both eyes TID." | |

aforementioned medication.

Further verification failed to show an order for the

On 08/28/18, at 6:20 PM, the LPN stated that the label for the Brimonidine eye drop was incorrect. The LPN then reviewed the MAR and the POS

book for the aforementioned order. At 6:24 PM, the LPN stated that she was not able find the

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/27/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 09G223 B. WING NAME OF PROVIDER OR SUPPLIER 08/30/2018 STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) W 388 Continued From page 7 W 388 order for the Brimonidine eye drop. On 08/29/18, at 9:44 AM, the QIDP presented an order for the aforementioned medication. According to a physician's order dated 03/02/17, one drop of Brimonidine was to be administered in the left eye BID. At 9:45 AM, the DON confirmed that the label was incorrect. The DON stated that she would obtain the correct label for the Brimonidine eye drop. At the time of survey, the facility failed to ensure that all prescribed medications were labeled in accordance with the physician order.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURV COMPLETED |
|---|---|---------------------|--|---|
| | 09G223 | B WING | | 09/20/20 |
| NAME OF PROVIDER OR SUPPLIER | STREETA | DDRESS, CITY, S | TATE, ZIP CODE | 08/30/20 |
| COMMUNITY MULTI SERVICE | S. INC | STON, DC 200 | | |
| PREFIX (EACH DEFICIENCY | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE CON THE APPROPRIATE D |
| 1 000 INITIAL COMMENT | -S | 1000 | | |
| from a population of | vas conducted from 08/28/18 Two residents were selected frone female and three males s of intellectual disabilities. | | | f), |
| and administrative re | | | | |
| Note: The below are appear throughout th | e abbreviations that may ne body of this report. | | | |
| GHIID - Group Home Intellectual Disabilitie DON - Direct of Nurs LPN - Licensed Prac MG - Milligram PCP - Primary Care I POS - Physician's Or PO - Physician Order | ing tical Nurse Physician der Sheets | | | |
| QIDP - Qualified Intel Professional RN - Registered Nurs BSP - Behavior Suppl | lectual Disabilities e ort Plan | | | |
| IPP - Individualized Pr TID - Three times a da BID - Two times a day MAR - Medication Adr | ay | | | n H |
| 1 401 3520.3 PROFESSION PROVISIONS | SERVICES: GENERAL | 401 | | |
| Professional services and evaluation, including developmental levels a services, and services deterioration or further resident. | nd needs, treatment | | | |
| Regulation & Licensing Administration of PROVIDERS | on UPPLIER REPRESENTATIVE'S SIGNAT | URPE | m Dacito | (X6) DATE |

PRINTED: 09/27/2018 FORM APPROVED

| Health Regulation & Licens STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | | | FORM APPROVI |
|--|--|------------------------|---|-------------------------------|
| | IDENTIFICATION NUMBER: | (X2) MULT A BUILDII | TIPLE CONSTRUCTION NG: | (X3) DATE SURVEY COMPLETED |
| | 09G223 | B. WING_ | | |
| IAME OF PROVIDER OR SUPPLIER | STREET AG | INDESS OF | Y, STATE, ZIP CODE | 08/30/2018 |
| OMMUNITY MULTI SERVICE | ES, INC | | | |
| (X4) ID SUMMARY STA | ATEMENT OF DEFICIENCIES | TON, DC | | |
| TAG REGULATORY OR L | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | HILD BE COMPLETE |
| 1401: Continued From pa | ge 1 | ! 401 | | |
| review, the GHIID n | met as evidenced by: on, interview, and record ursing staff (I) failed to ensure | | The prozac was started on a nursing staff will be retraine all physician orders/medical | d on reviewing reports |
| ordered, (II) failed to Brimonidine was ava | o ensure an order for | | and recommendations on tir | me. 10/19/18 |
| residing in the facility | y (Resident #1 and 4). | | The DON will review medica for compliance quarterly. | I records 10/19/18 |
| Findings included: | 2 | | | |
| inappropriate language to himself. Resident a program beginning at At 10:53 AM, the day Resident #1 to particitis peers and staff, but to talk to himself. | ge and was observed talking #1 was observed at his day to 10:48 AM talking to himself, program staff encouraged pate in a game of bingo with the refused and continued | | | |
| # 1 5 PSychiatry Asses | AM, review of Resident sment dated 06/01/18, dation to "add Prozac 40 Seroquel." | | | |
| On 08/29/18, beginnin Resident #1's MAR an an order for Prozac. | g at 10:15 AM., review of d POS book failed to reveal | | | |
| On 08/29/18, at 11:55 / QIDP revealed Resider Prozac because it was human rights committe | nt #1 did not start his | | | |
| On 08/30/18, at 9:44 Al revealed Resident #1's ordered within a couple psychiatrist prescribed to | M, interview with the DON Prozac should have been of days after the | | | |

| rieditti | Regulation & Licensin | | | | FORM APPROVI |
|--------------------------|---|---|-------------------------|---|-------------------------------|
| AND PLA | NT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | IPLE CONSTRUCTION NG: | (X3) DATE SURVEY COMPLETED |
| | | 09G223 | B WING_ | | 00/00/00 40 |
| NAME OF | PROVIDER OR SUPPLIER | STREET | ADDRESS CIT | Y, STATE, ZIP CODE | 08/30/2018 |
| COMMU | NITY MULTI SERVICE: | S. INC | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION) | IGTON, DC ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR | UID DE COURTE |
| J 401 | Continued From pag | je 2 | 1 401 | DEFICIENCY) | |
| | medication for Proza recommended by the 2. (Cross Reference beginning at 5:27 PM | c was ordered as psychiatrist. W388) On 08/28/18, I the LPN was observed | 9 | The order for the identified e was collected from the pharm placed in the MAR book. Pr will monitor for compliance n | nacy and imary nurse |
| | Resident #4's MAR ai an order for Brimonidi On 08/28/18, at 6:20 I | ng at 6:15 PM, review of nd POS book failed to reveal ine eye drops. | | The nursing staff will be retra the importance of obtaining p order sheet for each medicat administered. Primary Care r monitor for compliance mont | hysician ion urse will |
| , c | order. At 6:24 PM, the lot able find the order rop. | ok for the aforementioned LPN stated that she was for the Brimonidine eye | | | - |
| 0 e a | 3/02/17. It was then no nsure that the medical occordance with the Po | tioned medication dated eviewed by the surveyor to ation administered was in O. | | | |
| Bi | vices falled to ensur | ey, the facility's nursing re Resident #4's order for ained and available for on administration. | | | |
| (| | | | | |
| | | <u>a</u> | | | |
| | | | | | |

D9HG11

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/28/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 09G223 B. WING NAME OF PROVIDER OR SUPPLIER 08/30/2018 STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) E 000 : Initial Comments E 000 An emergency preparedness survey was conducted from 08/28/18 through 08/30/18. The findings of the survey were based on interviews and review of the emergency preparedness program. Note: The below are abbreviations that may appear throughout the body of this report. EPP - Emergency Preparedness Program QIDP - Qualified Intellectual Disabilities Professional RA - Risk Assessment RN - Registered Nurse E 006 Plan Based on All Hazards Risk Assessment E 006 CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop The facility's QIDP has contacted each and maintain an emergency preparedness plan Day Program and requested a meeting that must be reviewed, and updated at least to review their Emergency Preparedness annually. The plan must do the following:] Plan and Missing Person Policy and to (1) Be based on and include a documented, request a copy. facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based

on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.

10/19/18

LABORATORY DIRECTOR'S OR PROVIDERISUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

PRINTED: 09/28/2018

| CENTER | RS FOR MEDICARE | | FORM APPROVE | | |
|---------------|--|---|--|---|---|
| AND PLAN O | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED |
| NAME OF S | | 09G223 | B. WING _ | - I'motigaran | |
| | ROVIDER OR SUPPLIER ITY MULTI SERVICE | S, INC | | STREET ADDRESS, CITY, STATE, ZIP CODE | 08/30/2018 |
| (X4) JD | SUMMARY STA | TEMENT OF DEFICIENCIES | | WASHINGTON, DC 20012 | |
| PREFIX TAG | (EACH DEFICIENCY | MUST BE PRECEDED BY FULL CO IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY) | TRE COMPLETION |
| | | | | | |

E 006 Continued From page 1

- (2) Include strategies for addressing emergency events identified by the risk assessment.
- * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility (I) failed to collaborate with each client's day program to determine what arrangements where necessary to ensure that essential services could be provided during an emergency; (II) failed to establish emergency plans to address some of the hazards identified in the RA and (III) failed to establish emergency plans to address situations when clients are in the community for four (4) of four (4) clients residing in the facility (Client #1, 2, 3 and 4).

Findings included:

- (I) On 08/29/18, beginning at 4:05 PM, review of the facility's EPP dated 11/22/17 showed a lack of collaboration with the clients day programs to ensure that essential services would be provided in the event of an emergency.
- On 08/30/18, at 3:39 PM, the QIDP was asked during an interview if the facility coordinated with the clients' day programs to develop an EPP for when their at their day programs. The QIDP said "no" we did not include the clients' day programs into the development of the EPP based on the RA.

E 006 The facility will update the Risk Assessment to address all hazards that are identified as a significant threat to include a missing person policy. The policies will be reviewed annually and updated by the Program Director. 10/19/18

ED 91

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERVICES MEDICAID SERVICES | | | PRINTED: 09/28/20 FORM APPROVE |
|--|---|---------------------|--|-----------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
| | 09G223 | B. WING | | 220 |
| NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICE | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 08/30/2018 |
| PREFIX (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | ILLI D. BE COMPLETION |
| coordinate with the oplan for when clients during an emergence (II) On 08/29/18, bette facility's EPP data planning for emerger while the clients were During an interview of QIDP acknowledged provide guidance for | ginning at 4:05 PM, review of ed 11/22/17, showed no not events that might occur in the community. In 08/30/18 at 3:42 PM, the that the EPP failed to situations such as if a issued while the clients | E 006 | | |

At the time of the survey, the facility failed to ensure that the EPP addressed emergency situations when clients were away from the facility.

(III) During an interview with the QIDP on 08/29/18 beginning at 2:55 PM, the QIDP stated that the facility's RA had identified snowstorms, hurricanes, tornados and thunderstorms as the greatest potential hazards. The QIDP then added ice storms, blizzards, earthquakes, extreme heat, drought and wild fires as posing lesser degrees of risk.

On 08/29/18 beginning at 3:38 PM, review of the facility's RA, dated 11/22/17, showed "Supply Shortage" was determined to be of highest overall risk (at 61%). The next-greatest hazards listed were "Electrical Failure" and "Communications Failure" (at 56%). The RA showed the risk of "Information System Failure and Mass Casualty" was 44%, "Fuel Shortage, Fire, Flood, Structural Damage and Civil Disturbance" was 41%,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 09/28/2018 FORM APPROVED OMB NO. 0938-0391

| | | & MEDICAID SERVICES | _ | 14.04 | OMB NO. 0938-0391 |
|--------------------------|--|---|---------------------|--|-------------------------------|
| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | -1 | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED |
| | | 09G223 | B WING | | 08/30/2018 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 00/30/2018 |
| | JNITY MULTI SERVICE | | | WASHINGTON, DC 20012 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETION |
| E 006 | and "Transportation Thunderstorm" 33% and "Blizzard" was 2 On 08/29/18 beginn facility's EPP, dated evidence that the fact how to address miss failure, structural dates. | was 39%, "Generator Failure" Failure" was 37%, "Severe , and the risk of "Snow Fall" 28%. Ing at 3:55 PM, review of the 11/22/17, showed no cility had established plans on sing clients, transportation mage, mass casualty | E 00 | 06 | |
| E 007 | During a follow-up in PM, the QIDP acknot plans developed to a identified risks. EP Program Patient CFR(s): 483.475(a)(3) | 3) | € 00' | 7 | |
| : ! ! | and maintain an eme that must be reviewed annually. The plan m (3) Address patient/cl but not limited to, per services the [facility] I an emergency; and co | The [facility] must develop orgency preparedness plan d, and updated at least ust do the following:] ient population, including, sons at-risk; the type of has the ability to provide in continuity of operations, of authority and succession | | | |
| f F T I fa | nospice, PACE, HHA, FQHC, or ESRD facili This STANDARD is n Based on interview a | ot met as evidenced by: nd record review, the facility es and procedures in the | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/28/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 09G223 B. WING 08/30/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) E 007 - Continued From page 4 E 007 determined to be the most vulnerable in the risk assessment four (4) of 4 clients residing in the facility (Clients #1, 2, 3 and 4). Findings included: During an interview on on 08/29/18, at 2:55 PM, the QIDP stated that they had determined that Client #2 would be "especially at risk" during an emergency due to the client's weight, slow mobility and fall risk. The second most "at risk" client was Client #4 due to seizures and noncompliance. The third most "at risk" client was Client #1 due noncompliance and resistance to listening to women. On 08/28/18, beginning at 3:55 PM, review of the The facility's QIDP has revised the PEEP facility's EPP, dated 11/22/17, and Clients #2, 3 for Client #2, #3 and #4 to address and 4 individualized EPP (not dated), revealed each client's risks in the event of an that neither plan reflected the aforementioned risk emergency. 10/19/18 or the need to have an assigned one-to-one staff. Further review revealed an EPP was not developed for Client #1. On 08/30/18, beginning at approximately 2:58 PM, the QIDP examined the client's EPP. The QIDP acknowledged that the client's risk was not addressed in the EPP. In Addition, the QIDP stated that Client #1 did not have a plan.

The individualized PEEP for Client #1 will be developed, reviewed and signed by Client #1's guardian. 10/19/18

E 035

emergency.

CFR(s): 483.475(c)(8)

At the time of the survey, the facility's EPP failed

to address vulnerable clients in the event of an

(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness

E 035 LTC and ICF/IID Sharing Plan with Patients

018 /ED 91

| DEPARTMENT OF HEALTH A | & MEDICAID SERVICES | | | PRINTED: 09/28/2 FORM APPROV OMB NO. 0938-03 |
|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | 09G223 | B WING_ | | 20/20/20 |
| NAME OF PROVIDER OR SUPPLIER | | ' T | STREET ADDRESS, CITY, STATE, ZIP COD | 08/30/2018 |
| COMMUNITY MULTI SERVICES | | | WASHINGTON, DC 20012 | |
| PREFIX (EACH DEFICIENCY N | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETIC |
| E 035 Continued From page | e 5 | F 03 | 5 | |
| communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This STANDARD is not met as evidenced by: Based on record review and interview, the facility | | E 035 The facility will develop a written plar the EPP that will contain methods within the Communication Plan that will give guidance for sharing information for the client's families or representate during an emergency. The Program Director will review plan annually. QIDP made contact with family/guard | | |
| representative had bee | client's family member or en given information emergency plan, for one in the facility (Client #1). | | via email and received appr Client #2, #3 and #4. Client developed and approval from will be completed. | #1 has been |
| Findings included: | | | | |
| facility's EPP dated 11/2 | g at 4:05 PM, review of the 22/18 showed no evidence ed with Client #1's family ians. | | | |
| interview that an EPP for | I, the QIDP said during an or Client #1 had not been tated that the EPP would | | | |

At the time of the survey, the facility failed to ensure the client's family members and/or guardians received an EPP for each client,

be developed and emailed to Client #1's family

member and guardian.